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Psychological Experiences and Vulnerability of Lesbians, Gay, Bisexual, Transgender (LGBTI) in Access to Quality Health Care Services in Rural Areas of Zimbabwe

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Abstract:
LGBT is an acronym for lesbians, gay, bisexual and transgender individuals who are characterised by sexual behaviour, identity, and desire. These individuals are most discriminated and stigmatised as a result of legal, cultural and religious landscape. LGBT are a hidden or invisible population with disproportional risks to health infections. The LGBT are placed outside prime laws of the land hence they are vulnerable to abuse, rejection and face some hindrances in accessing quality health care, education, and other social services. Accessing needed health care services is among the most daunting challenges that LGBT community confronts especially in the rural settings. Religiosity and cultural values, acts as a bigger impediment to access health care of people who practice 'same gender loving' in Sanyati rural areas of Zimbabwe. The LGBT experience sexual act through intercrural sex, fellatio, hand-jobs, foot-jobs, inter-gluteal sex, mammary sex, oral and axillary sex. The study used the Transformative Paradigm (TP) and Critical Emancipatory Research (CER) as the beacon of the research. This research design enables the researcher to explore the problems faced by LGBT population in accessing the much-needed health care services and their vulnerability. Data was gathered from the lesbians, gays, transgender and bisexual on their experience and vulnerability in accessing health care services in rural areas. Data was collected through social medial platforms and face to face through a snowball sampling and opportunistic sampling technique. The research findings revealed that LGBT face challenges of accessing the needed health care services due to fear of coming out, discriminatory and incompetent healthcare, lack of information, underrepresentation and lack of confidence. The study recommends opening up referral clinics in rural areas and offer education on the effects of not seeking health care services. The study also predicts that HIV/AIDS will not end so early due since the key population are left out as a result of legal and cultural issues.

Keywords: *Lesbians, gays, bisexual, transgender, HIV/AIDS*

1. Introduction

Worldwide, the traditional cultural practices have pushed the lesbians, gay, bisexual, transgender, men having sex with men and intersex (LGBT) to be a hidden or invisible population with disproportional risks to healthy infections(Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2018). The criminalisation of LGBT populations in other communities has placed them outside supreme laws hence they are subject to abuse, discrimination, and this hinders their access to quality health care, education, and other social services. In Zimbabwe there is big variance in the acceptance of homosexuality yet this population exists. In the rural communities where, cultural values are being protected most and there is high rigidity in acceptance of 'same gender loving'. Therefore, there are numerous challenges facing LGBT people and attempts to address these challenges often confront deep-seated resistance due to cultural and religious resistance. According to Kates, Ranji, Beamesderfer, Salganicoff, & Dawson (2018) LGBTI experience severe unique health challenges. These challenges include gaps of being open- up, cost-related hurdles, stigma, poor treatment from health care providers in rural areas where health services are at its 'sorry state' in Zimbabwe.Hudson-Sharp & Metcalf (2016) view that LGBTI people face substantial discrimination, harassment, disadvantage and inequality in major aspects of life such as education,

health and care, services, victimisation, employment. In the African communities the understanding of sexual health seeking behaviours and vulnerabilities is paramount when addressing issues of sexual transmitted infections(STI) and psychological demands such as counselling.

Accessing needed health care services is among the most daunting challenges that LGBT community confronts especially in the rural settings. LGBT used to be there since time immoral. There is need to view the identity of LGBT with the global lens not with the limited African lens. In most developing countries LGBT people who seek health care services encounter rejection, humiliation, derision, or at best sub-standard services, leading to pronounced health disparities. Sex is an autonomic system influenced by adrenal hormones in the bloodstream (Dubrovsky, 2005).This implies being a homosexual or a heterosexual is a hormonal command which cannot attract prosecution or criminalisation since it is about automatic responses. Therefore, basing on the above, cultural or religious beliefs are null and void to determine the legality or acceptance of sexual choice. It is difficult for individuals residing in rural areas to access quality health care services unlike in urban community where some referral initiatives had been put in place. The study was triggered by the paucity of local literature on appreciating the presence of LGBT and how they safely access quality health care services in rural areas of Zimbabwe as a way to reduce global health problems. The failure to address LGBTI people's sexual health needs is to some extent symptomatic of a more general failure of the broader sexual minority spectrum.

1.1. Background and Generic Overview of LGBT

The act of same-sex orientation is criminalized in more than 70 countries, and in some countries convictions for LGBTI people carry death sentences (Russel& Fish, 2016). Criminalization reinforces intolerant social norms in wider society that demonize LGBT people and permeate public service culture. In countries where same-sex acts are illegal. LGBT people's fear of disclosing their sexual orientation to medical personnel often prevents them from seeking health services. Access to health care services is fundamental human right to all human beings in the world despite their sexual orientation. There are major gaps in health data and demographic information about LGBT people, mainly due to criminalization and the refusal of most governments to acknowledge the presence of sexual and gender minorities. This has led LGBT people to be reluctant in disclosing their sexual orientation and identity for fear of abuse, victimization or face other negative consequences. In Zimbabwe little is known regarding how LGBT population access care health services in rural areas. Given the diversity of the LGBT community, it is prudent to understand sexual identity labels and needs of LGBT people which are unaddressed. Religiosity and cultural values, acts as a bigger impediment to access the practice of same sex in rural areas of Zimbabwe. Zimbabwe is a Christian dominated environment and the biblical teachings strongly condemn same sex practices. The globalisation principle has accommodated and universalised human rights such as sexual identity, sexual orientation among others. The 'same gender-loving' has lured the lens of the researcher to address the challenges faced by the LGBT in accessing quality health care services. The heterosexual individuals are motivated to seek and access health care services without any impediment. This study is to address the health seeking behaviour of LGBT individuals who resides in the rural communities of Kadoma which is in Sanyati District.

According to an analysis of the 2006-2010 National Survey of Family Growth, more than one-quarter (28%) of lesbian and bisexual women are poor, compared with 21% of heterosexual women. Just over 1 in 5 gay and bisexual men (23%) are poor, compared to 15% of heterosexual men. However, when comparing couples, lesbian couples have the highest poverty rates, followed by heterosexual couples and male same-sex couples (Kates et al, 2018). The above suppositions entails that the lesbians, gays and bisexual are the vulnerable community due to the legal and cultural landscape. This would lead them to be the poorest group especially the rural areas of Zimbabwe where there is relative poverty and they experience worse health care outcomes due to poor infrastructure. In 2018, 50% of HIV positive men who have sex with men were estimated to be aware of the HIV status. These findings were based on limited data so may not accurately represents the reality of the situation in Zimbabwe.

Sanyati district is in Mashonal and West province of Zimbabwe. Artisanal mining is a key source of livelihood in the district, characterised by hive of activities of panning, gridding, crushing, through restauranteering, selling diverse goods, or prostitution. The artisanal mining activities can be referred to as illegal mining. The general image of artisanal mining considers the sector to be chaotic, illegal and even criminal (Geenen, 2014). It is seen as a 'world apart', where drug abuse, sexual violence, human rights abuses, criminality and prostitution prevail (Cuvelier 2011; Free the Slaves, 2013; Werthmann, 2003). There are challenges that can be encountered in artisanal mining such as the practices of unsafe sexual activities, prostitution, violence and many more. Sanyati district has the highest STI infections in Zimbabwe (Population Service International, 2020). Therefore, since prostitution is highly practiced and there are highest chances that same sex is regarded as a deviant behaviour. Considering the above challenges, it is clear that individuals who practices same gender loving are at highest risks of being negated in accessing health care services. How are the LGBT access health care services in the STI infested area? The LGBT individuals are there in these mining communities and they are the vulnerable of the vulnerability.

Kates, Ranji, Beamesderfer, Salganicoff, & Dawson (2018) argue that sexual orientation and gender identity are important aspects of an individual's identity as they interact with other factors such as sex, race, ethnicity or class to determine and helps to shape an individual's health, access to care, and experience with the health care system. Ard and Makadon (2017) LGBT is an acronym which represents a wide range of individuals who are discriminated and stigmatised as a result of cultural and religious backgrounds. These individuals are regarded as the key population who are characterised by sexual behavior, identity, and desire. According to Kates, Ranji, Beamesderfer, Salganicoff, & Dawson (2018) gender identity is internal, one's gender identity is not necessarily visible to others.In this study the terms 'men who have sex with men' (MSM) and 'women who have sex with women' (WSW) are often collectively used to describe

those who engage in same-sex and are interchangeably used as gay and lesbians respectively. According to Potter (2008) prefers to identify these individuals as 'same-gender loving'. The term transgender is an umbrella term to describe individuals who do not conform to the traditional notion of gender in which one's gender expression or desired expression is consistent with one's birth sex (Ard&Makadon, 2017). Transgender individuals may alter their physical appearance order to affirm their preferred gender identity. Eliason (2001) posits that the bias faced by LGBT individuals due to their sexual orientation or gender identity hinder them from accessing quality health care services.In addition, not all persons who engage in same-sex behaviour or experience same-sex attraction identify as lesbian, gay, or bisexual.

LGBT individuals just like the heterosexual people can be infected with sexual transmitted infections (STI) such as HIV&AIDS, syphilis and many more. The infection of HIV& AIDS has psychological effects such as depression, trauma, anxiety which can lead to suicidal tendencies since the diseases a most feared and is a death coiled monster.The prevalence of LGBTI is still a challenge since the group are a hidden population due to criminality. Estimates of self-identified LGBT individuals also vary by state. Therefore, it is prudent to have respect for human rights since they are a foundational principle underlying international agreements such as the 1948 Universal Declaration of Human Rights.

The health care deficiency stem from structural and legal factors, social discrimination, and lack of culturally-competent health care.In the African communities the understanding of sexual health seeking behavioursand vulnerabilities is paramount when addressing the issues of sexual transmitted infections.Ard&Makadon (2017) indicate that individuals in same-sex relationships are significantly less likely than others to have health insurance, are more likely to report unmet health needs. Every individual in susceptible to contract health challenges and LGBT cannot be spared. For instance, eating disorders and body image disorders are more common among gay and bisexual than heterosexual men (Ruble, 2008). Research by Lee (2009) indicates that members of the LGBT population are mostly likely to endure to drug and substance abuse which would trigger them to seek health services. In some LGBT sub-populations, such as gay men and male-to-female transgender persons, drug use is associated with unsafe sex and the transmission of infections, including HIV (Mayer, 2008). Several studies have also suggested higher rates of depression, anxiety, and suicidal ideation among gay, lesbian, and bisexual individuals (Ruble, 2008). All the above stated health challenges need an individual to look for health care services. Therefore, LGBT people faces a common set of challenges in accessing culturally- competent health services and achieving the highest possible level of health.

In Zimbabwe same sex is morally and culturally unaccepted especially in rural settings. The criminalisation and negative attitudes towards same sex behaviour contribute to lack of surveillance epidemiological data among the LGBT population (Manhandu-Mudzusi, 2016).Brunk (2017) argues that MSM and transgender people are entitled to full protection of human rights as stated in the Yogyakarta Principles.These include the rights to the highest attainable standard of health, non-discrimination and privacy. Arndt and de Bruin (2011) support that punitive laws and law enforcement practices, stigma and discrimination undermine the effectiveness of sexual health programmes, which limits their ability to reach MSM and transgender people. Therefore, the criminalization, and legal and policy barriers play a key role in the vulnerability of LGBT people to diseases such as AIDS & HIV. Vulnerability is innate to all humans and is highly influenced by community, social, and environmental factors interacting in a temporal relationship (Aday, 2001). It is important to ensure that the promotion of legal and social environment protects human rights and ensures access to prevention, treatment, care and support without discrimination or criminalization to homosexual individuals who resides in rural mining areas of Kadoma.

From a health systems' perspective, MSM and transgender people may delay or avoid seeking health, STI or HIV-related information, care and services as a result of perceived homophobia, transphobia, ignorance and insensitivity. MSM and transgender people may be less inclined to disclose their sexual orientation and other health-related behaviours in health settings that may otherwise encourage discussions between the provider and patient to inform subsequent clinical decision-making. Additionally, enquiry into the level of knowledge among health-care providers on MSM and transgender-related health issues has shown that the clinical training curriculum, particularly in low- and middle-income countries, do not address these knowledge gaps (UNAIDS, 2011).

According to Muller (2016) transgender people are almost everywhere denied legal recognition of their gender and may also be penalized by laws which criminalizes same-sex behaviour. Sexual orientation is a complex construct comprised of sexual attraction, sexual behavior, personal identity, romantic relationships, and community membership (Herek, Norton, Allen, & Sims, 2010). Laws and policies that criminalize same-sex sexual relationships use give license to discrimination, harassment and hindering them from accessing vital health care services. Therefore, the acknowledgement of the existence of transgender and MSM can be a positive move to reduce HIV prevalence globally. Accessing health care services is among the most daunting challenges the LGBT community confronts. In many developing countries LGBT people who seek health care services of any kind encounter rejection, humiliation, derision, or at best sub-standard services, leading in some cases to pronounced health disparities among LGBT populations.

1.2. Psychological Health and Well- Being of LGBT

Psychological health is key to human wellness. The treatment of LGBT is most communities across the globe is laced with pattern of low self-esteem and self-confidence, as well as social isolation, social anxiety and stress, likely leading to feelings of helplessness and depression, risk-taking behaviours (UNDP, 2012).

1.3. Risk Sexual Behaviour

It is known that unprotected receptive anal intercourse (URAI) is a high-risk sexual behaviour that is experienced by some LGBT, hence put them at a greater risk of HIV infection. The risk of transmission is around 18 times higher than

for vaginal intercourse (UNDP, 2012). Gates (2011) reviews that studies in Fiji and in Japan posits that transgender woman enjoys sexual gratification through several methods such as intercrural sex (sex between the thighs, sometimes called interfemoral sex). The work of Hudson-Sharp& Metcalf (2016) indicates that the Japanese transgender are more prone to fellatio and sumata that is rubbing the penis with various parts of the body. According to Global Commission on HIV and the law (2011) the other examples may be hand-jobs, foot-jobs, inter-gluteal sex (penis between the buttocks), mammary sex (penis between the breasts), and axillary sex (penis in the armpit), as well as presumably less-safe-but-low-risk practices such as frotteurism (penis-to-penis masturbation). All the above behaviours made the LGBT population to be at risk of contracting sexually related infections. UNDP (2012) argues that in Thailand and the Chinese LGBT individuals risk themselves by using the 'backyard' or unqualified health personnel to implants hormones or do gender affirming surgeries.Therefore, this clearly means that the shortcomings of LGBT healthcare extend to sexual health services. In view of the artisanal rural setting such as of Kadoma, the above suppositions clearly show that talking or discussing the health demands of the key population such as the 'same gender loving' or homosexuality is a taboo.

1.4. Health Care Services

The access of health care services among the LGBT is commonly under-serve in developing countries such as Zimbabwe. This resonates with UNDP (2012) in the Asia-Pacific region, where healthcare providers are seen as uncooperative, hostile, mocking or having ridiculing attitude, withholding or refusing healthcare, or even offering 'reparative' treatments to the key population like LGBT. This simply shows that access to healthcare services is not a straightforward process. In Kuwait HRW (2012) there are cases of doctors refusing to treat LGBT and end up reporting them to police for breaking the law on impersonation of the opposite sex. UNDP (2012) estimates that confidentiality is not always assured, especially in regard to mandatory HIV testing for LGBT in countries where homosexual is regarded as illegal.

1.5. Aim of Study

This paper seeks to acknowledge sexual orientation and redress the imbalances faced by LGBT in accessing quality health care services in rural areas.

2. Methodology

2.1. Research Design

This was an exploratory qualitative research which involves an in-depth interview with LGBT people who resides in Sanyati rural District who are the LGBT. The secondary data of desk research from other researchers was also used to gather data since these LGBT are not easy to find due to legal and cultural issues. The main purpose of the study was to fish out the psychological experiences and challenges of accessing healthcare services as well as to find way of how to improve their services in future.

2.2. Population and Setting

For this study sexual and gender minorities (LGBT individuals) were used. The selection was focused on those socially excluded populations whose sexual behaviours promote higher incidence of infectious and non-communicable life-limiting illness due to risk behaviours which may be linked to discrimination. In Zimbabwe, LGBT people are legally and socially marginalised. The snow-ball and purposive sampling was used to select the participants.

2.3. Data Collection

The researchers gathered data through face to face and also used an anonymous in-depth interview questions in which participant answered social media platforms of WhatsApp and Facebook. In depth interviews involves conducting intensive individual interviews so as to explore individual perspectives on a particular idea or situation (Creswel, 2011). The in-depth interview is so useful when the researcher wants to find detailed information about the person's thought and behaviour such that of the key population such as the LGBT. The researcher also employed the use of interactions with participants via text and audios. Responses were recorded in a document form.

2.4. Ethical Reflections

Ethics is an important characteristic in any research. Recruitment was undertaken with clear safety protocols to minimise risk to participants and researchers. A distress protocol was developed in case any interviewee becomes distressed, fatigued or unable to continue for other reasons. Interviews were conducted in safe places. Before starting the interview and having received an explanation of the study, each participant signed a consent to record and a separate participation consent form. Confidentiality was ensured throughout the research process.

2.5. Data Analysis

Data was transcribed verbatim and analysed using thematic analysis which has five key stages: familiarisation, coding, theme development, defining themes and reporting. The first stage of analysis was familiarisation where the researcher read and realign the transcripts alongside research objectives. Transcripts were then coded within the core areas of the interview schedules. Additional themes not captured in the core areas were also noted during analysis and added to the thematic compilation. The researcher interprets and reports the findings.

3. Results

The study explored the psychological experiences and the vulnerability of lesbians, gay, bisexual and transgender (LGBT) in accessing quality health care services in rural areas. The findings creamed out different themes which are:

- Fear of coming out
- Discriminatory and incompetent healthcare
- Lack of information
- Underrepresentation and lack of confidence

3.1. Fear of Coming Out

All the participants emphasised that they are not yet comfortable to open up. The constitution of the country does not recognise their existence. The main point which is forcing the LGBT individual to hide is the legal protection. Many were concerned about confidentiality if they disclosed their sexual orientation to health workers, as well as about judgmental attitudes, ignorance and homophobia. However, most participants boasted that there are so many LGBT in all communities and they also practice sexual activities just like the heterosexual counterparts. *There is no sex which can be done at the public.* This means that they respect secrecy when practising sexual activities. The other participant indicated that sexual gratification of same sex is far much more pleasurable than that of same sex.

The research found that there are so many homosexuals in the communities. Most respondents pointed that most of them are both homosexual and heterosexual so that they can counter the issue of discrimination and stigma. This means there are high chances of being infected by STI and the issue of ending HIV/AIDS is far from ending. Therefore, from the above responses it is prudent to be flexible in recognising the LGBT. If the LGBT individuals are not coming out in urban areas where life is more individualistic it will be so difficult so LGBT individuals in rural areas where life is more collective. This entails that due to collective cultural practices 'same gender loving' are at risk and does not seek or access needed health care services such as condoms and health education in their rural areas due to fear cultural deviants.

3.2. Discriminatory and Incompetent Healthcare

Prejudice and discrimination linked to sexual orientation was seen as causing physical health problems. Discrimination is one of the notable barriers which is forcing the LGBT individuals to access the needed health care services. The respondents indicated that there is legal discrimination, socio-cultural as well as psychological discrimination. Discrimination is the pivot of medical accessibility. This is in par with the research in Kuwait HRW (2012) where cases of doctors refusing to treat LGBTI and end up reporting them to police for breaking the law on impersonation of the opposite sex. The other respondent points out that *'Some of the health workers fear us.* This would also compromise confidentiality hence putting the LGBT at risk of accessing much needed health care services. This means there is higher dissatisfaction with health services amongst LGB people than heterosexual people. Experience of discrimination including lack of recognition of one's partner; reaction to a patient saying they are LGBT, invisibility of LGB people and information on their health needs and lack of knowledge on LGBT health needs. Therefore, most LGBT people are reluctant to be disclose their sexual orientation and this can exacerbate problems in securing appropriate treatment. The other respondent indicated that they are discriminated by the distance they move to access quality health care services. In spite of initiating strategies of counter label of being homosexuals in rural areas most individuals move more than ten kilometres to access health care services and this will automatically cause them not to access health care services hence putting their life in danger. The health personnel are also not competent to address health challenges faced by LGBT such as complicated STI, urinary infections and psychological problems such as depression, trauma, anxiety and many more. In rural health facilities there are no medical expects such as physicians and psychologists who can address the challenges faced by LGBT. One participant explains that there are very few clinics which cater for the LGBT people and this put them at risk.

3.3. Lack of Information

Information and knowledge are key to address any challenge in human life. The research found that the Sanyati community is not empowered on how to address LGBT health problems in rural areas. It is a taboo to talk about homosexual in most rural areas since most community elders doesn't believe on the existence of this group of people. LGBT people are also not empowered on the consequences of not accessing health care services and also lack knowledge of voluntary HIV/AIDS testing. Therefore, lack of information relevant to sexual orientation or gender identity, inappropriate questioning about sexual health and lack of recognition of treatment diminish the International health funding for HIV/AIDS. The researcher noted from the secondary data that there is much criticism on the medical approach towards gender identity, which is seen as a 'one size fits all' approach, and not recognising the diversity of transgender people's experience. This meant that some transgender people ignored their own experience and had to fit with health specialists' expectations especially in vulnerable communities like the rural areas. These conclude that the LGBT individuals who reside in rural areas are most vulnerable and are at risk to encounter health challenges.

3.4. Underrepresentation and Lack of Confidence

The research found that since the LGBT population are not recognised by the law they are not represented. The participants pointed that there are secret organisations which are well funded which assist them but it is difficult for any individual in rural areas to know these organisations. This means LGBT individuals in rural are vulnerable and they do not seek health care services due to cultural and environmental barriers. LGBT population lack confidence of saying out their

grievance and seeking health care services for fear if victimisation.Furthermore, indication of LGBT people's greater lack of confidence in medical services, was their concern about medical professionalism in confidentiality and later pointed that there should be referral clinics in rural areas which can address the health needs of LGBT.Therefore, LGBT people view themselves as a rejected and negated population. This lack of images of same-sex couples and families made LGBT people feel unwelcome within health services. Other gay participant posits that *being gay is a side chick partner with opposite sex partner for fear of being discriminate.*The majority respondents reported having been assumed to be heterosexual out fear of being victimised and very few had reported receiving sexual health information suitable to their gender identity or sexual orientation. This clearly means that LGBT people are always vulnerable and lack knowledge and courage to seek health care services.

3.5. Identification of LGBT

The research found that some LGBT identify themselves through selling sex toys and others use secret code of identity which they refused to share with the researchers. The secret codes range from dress code and hair style codes which the general population is not familiar with. Most of them display behaviours which contradicts their sexual identity. Some respondents boasted that they are controlling the world in the name of fashion. This means that most fashionable dressing which represents the dress code of the LGBT. Most of the participants indicated that they identify themselves as the heterosexual so that they cannot be discriminated by the community. This will enable them to access the needed health care services without fear. However, the LGBT cry foul as they need to freely identify themselves with their counterparts. The other participant indicated that to identify with others there is need to use hook-ups and emphasised one no need to go around looking for the lesbians or the gays.

3.6. Sexual Act of LGBT

The researcher asked how they practice same sex. Most LGBT revealed that sex act is privacy for both heterosexual and same sex loving. It remains criminal to practice sexual act in public globally. The responses on how they practice sexual acts resonates with Hudson-Sharp& Metcalf (2016) where sexual gratification is through several methods such as intercrural sex, fellatio and sumata that is rubbing the penis with various parts of the body, hand-jobs, foot-jobs, inter-gluteal sex (penis between the buttocks), mammary sex (penis between the breasts), and axillary sex (penis in the armpit), as well as presumably less-safe-but-low-risk practices such as frotteurism (penis-to-penis masturbation) and most common which is oral sex. One lesbian indicated that they use the Dildo which is a penis sexy toy to practice sex acts and they can exchange to wear a Dildo. However, she went on to express that the Dildo has no side effects and they are so safe. The respondents indicated that the list is endless but these are the most common practices. All these sexual acts expose the LGBT to contract different diseases which later needs them to access health care services. Generally, the research found that sex is inevitable and is medicinal to humankind.

3.7. Chronic Health Illness

One of the most significant health challenges facing the LGBT community has been the HIV/AIDS epidemic. These individuals need to access antiretroviral therapy and condoms so that they can practice safe sex. LGBT individuals are at elevated risk for some mental health and behavioural health conditions, with studies finding that they are more likely to experience depression, anxiety, and substance misuse. These mental health challenges are precipitated by discrimination and family rejection. The evidence suggests that the sexual health of lesbians and bisexual women is neglected, both in terms of prevention of sexually transmitted diseases and of sexual fulfilment. Therefore, difficulty in accessing health care services would lead to chronic healthy illnesses such as HIV/AIDS, sophisticated STI, syphilis, mental illness and other chronic related illnesses. These chronic health illnesses are worse experienced in rural areas which individuals work a long distance to access health care and where health education is still limited.

3.8. Challenges Faced by LGBT

All the respondents pointed that they face challenges of being discriminated and of expressing out their desire since they are not protected by the law. All the participants argued that they are either lesbians or gay not by choice but its natural cause because of their hormonal command. One lesbian point out that some of their sex partners are also not faithful which can cause stress and depression just like the heterosexuals. Lack of sexuality education is one of the major challenges that people in rural areas face. There is little evidence to inform prevention interventions or how to encourage thesepeople to use HIV services. This means HIV education is lacking for these individuals. Denial among the members of the LGBT was also another notable problem. They face denial especially when they are infected with STI such as HIV/AIDS. This denial destroys their self-esteem and zeal to seek medical help and others fail to adhere to treatment instructions which could compromise their health. Criminalisation of homosexuality drives away these vulnerable individuals from accessing health care services.

4. Conclusions, Recommendations and Predictions

It emerged from the present study that LGBT are a hidden and invisible population but are an existing group. The study understands that some heterosexuals are also homosexual for fear of community rejection and discrimination. It has been noted that although these individuals are not recognised by the law, they identify each other through secrets codes such as dress or hair styles and other notable behaviours. The study found that LGBT individuals are always at risk of accessing health care services because of fear of coming out, discriminatory and incompetent healthcare, lack of

information, underrepresentation and lack of confidence. The study undertook that there is still patchy knowledge on addressing the accessibility of quality health care among the LGBTI key population. Due to the patchiness in the research, there is much which is unknown about the health and health care of gay and lesbians in rural communities.

It is prudent to create an environment inclusive and safe for self-disclosure for LGBT people to access health care facilities. The professionals should be empowered to be non-judgmental on sexual identity and orientation and this enable to building trust with LGBT patients. There is need to introduce patient-centred medical home which can be used to end LGBT invisibility in health care facilities and can help those located in rural areas not to walk long distances. There is also need to mobilise for confidential visitation hours among the key population such as sex worker and LGBT to access medicines.There is need to build a partnership in solidarity with LGBT and civil society actors. Lastly the study recommends to create a confidential referral mechanism by mapping the needs of LGBTindividuals.

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